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**MARTIN S. CHATTMAN, M.D.**

Case No. MD-09-0279A

## CONSENT AGREEMENT

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that he has the right to consult with legal counsel regarding this matter.

3. This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

5. This Consent Agreement does not constitute a dismissal or resolution of other matters currently pending before the Board, if any, and does not constitute any

1 waiver, express or implied, of the Board's statutory authority or jurisdiction regarding any  
2 other pending or future investigation, action or proceeding. The acceptance of this  
3 Consent Agreement does not preclude any other agency, subdivision or officer of this  
4 State from instituting other civil or criminal proceedings with respect to the conduct that is  
5 the subject of this Consent Agreement.

6       6. All admissions made by Respondent are solely for final disposition of this  
7 matter and any subsequent related administrative proceedings or civil litigation involving  
8 the Board and Respondent. Therefore, said admissions by Respondent are not intended  
9 or made for any other use, such as in the context of another state or federal government  
10 regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or  
11 any other state or federal court.

12       7. Upon signing this agreement, and returning this document (or a copy thereof)  
13 to the Board's Executive Director, Respondent may not revoke the acceptance of the  
14 Consent Agreement. Respondent may not make any modifications to the document. Any  
15 modifications to this original document are ineffective and void unless mutually approved  
16 by the parties.

17       8. If the Board does not adopt this Consent Agreement, Respondent will not  
18 assert as a defense that the Board's consideration of this Consent Agreement constitutes  
19 bias, prejudice, prejudgment or other similar defense.

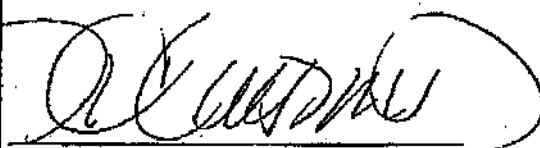
20       9. This Consent Agreement, once approved and signed, is a public record that  
21 will be publicly disseminated as a formal action of the Board and will be reported to the  
22 National Practitioner Data Bank and to the Arizona Medical Board's website.

23       10. If any part of the Consent Agreement is later declared void or otherwise  
24 unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force  
25 and effect.

1 11. Any violation of this Consent Agreement constitutes unprofessional conduct  
2 and may result in disciplinary action. A.R.S. § 32-1401(27)(r) ("violating a formal order,  
3 probation, consent agreement or stipulation issued or entered into by the board or its  
4 executive director under this chapter") and 32-1451.

5 12. Respondent acknowledges that, pursuant to A.R.S. § 32-2533(E), he cannot  
6 act as a supervising physician for a physician assistant while his license is restricted.

7 13. *Respondent has read and understands the conditions of probation.*

8  
9   
10 MARTIN S. CHATTMAN, M.D.

DATED: 7-16-09

11  
12 REVIEWED AS TO FORM:

13   
14 PAUL J. GIANCOLA

DATED: 7.16.09

15  
16 FINDINGS OF FACT

17 1. The Board is the duly constituted authority for the regulation and control of  
18 the practice of allopathic medicine in the State of Arizona.

19 2. Respondent is the holder of license number 7618 for the practice of  
20 allopathic medicine in the State of Arizona.

21 3. The Board initiated case number MD-09-0279A after receiving a complaint  
22 regarding Respondent's care and treatment of a fifty-six year-old female patient ("SR").

23 4. In December 1997, SR established care with Respondent for reported  
24 migraine headaches. Respondent's initial evaluation did not include a documented review  
25 of any prior medical records or diagnostic testing. Over the next four years, with the  
exception of between May 2000 and January 2002, Respondent prescribed large

1 quantities of codeine/barbiturate products and benzodiazepines. There was no  
2 documentation of SR's headaches, her response to the medications, any side effects or  
3 whether Respondent monitored her compliance with the medications. Respondent's  
4 records for SR were sparse and did not include a treatment plan; however, there was  
5 documentation that SR was at high risk for substance misuse and on June 28, 1999, SR  
6 reported an episode regarding lost medications. However, there was no indication that  
7 Respondent followed up on this.

8       5. In 2002, 2003 and 2004 Respondent recommended SR obtain psychiatry  
9 and neurology consultations; however, SR did not obtain the recommended specialist  
10 consultations for migraine or psychiatric conditions documented in the medical records. In  
11 2004, a family member contacted Respondent and reported that SR did not take the  
12 medications as directed and that she was addicted. In response, Respondent discussed  
13 with SR her use of pain medications and addiction, and referred her for pain management  
14 and psychiatric consultations, but SR refused. Respondent continued to prescribe for SR's  
15 various acute and chronic complaints large quantities of codeine containing products and  
16 benzodiazepines on a frequent basis. In October 2002, January 2003 and July 2005,  
17 Respondent noted that SR was seeing a neurologist. In 2006 and 2007, there was only  
18 one documented office visit for each year for worsening headache pains; however,  
19 Respondent prescribed large quantities of codeine containing tablets, Diazepam tablets  
20 and controlled substances to SR without documenting an associated office visit or any  
21 indication for the prescriptions.

22       6. Respondent stated that he was not aware that SR was also seeing at least  
23 five other prescribers for medication. Respondent continued to prescribe benzodiazepines  
24 and Fiorinal through September 2008 even though SR reported in February 2008 that she  
25 had obtained medications over the internet. Respondent documented that he had a

1 growing sense that ongoing prescribing was not in SR's best interest he encouraged her to  
2 take less medication and see a pain specialist; however, the prescribing continued.  
3 Subsequently, in September 2008, SR informed Respondent that she was moving to  
4 California and requested a prescription for Fiorinal in an amount sufficient to last until she  
5 was able to establish care with a new physician. Respondent provided SR with an early  
6 renewal for Fiorinal with refills. Respondent noted that he would no longer provide  
7 prescriptions for SR. Two weeks later, SR died from an overdose.

8         7. The standard of care for prescribing long-term opioid medications for chronic  
9 nonmalignant pain requires a physician to perform appropriate evaluations of the pain  
10 problem, obtain a history and perform a targeted physical exam that includes reviewing  
11 past medical records and medication history; to monitor the patient for efficacy and  
12 adverse effects of the medications and to recognize and follow up on problems suggestive  
13 of noncompliance and/or aberrant drug seeking.

14         8. Respondent deviated from the standard of care because he did not perform  
15 appropriate evaluations of SR's pain problems, obtain her history or perform a targeted  
16 physical exam that included reviewing her past medical records and medication history; he  
17 did not monitor SR for efficacy and adverse effects of the medications and he did not  
18 recognize or follow up on problems suggestive of noncompliance and/or aberrant drug  
19 seeking.

20         9. SR fatally overdosed. SR's worsening headache pain may have been due to  
21 analgesic rebound and overprescribing. There was potential of perpetuation of addictive  
22 tendencies and brain damage.

23         10. A physician is required to maintain adequate legible medical records  
24 containing, at a minimum, sufficient information to identify the patient, support the  
25 diagnosis, justify the treatment, accurately document the results, indicate advice and

1 cautionary warnings provided to the patient and provide sufficient information for another  
2 practitioner to assume continuity of the patient's care at any point in the course of  
3 treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because he did  
4 not document a review of any prior medical records or diagnostic testing; he did not  
5 document SR's headaches, her response to the medications, any side effects or whether  
6 Respondent monitored her compliance with the medications; he prescribed medications  
7 without documenting an associated office visit or any indication for the prescriptions and  
8 SR's records were sparse and did not include a treatment plan.

#### 9 10 CONCLUSIONS OF LAW

11 1. The Board possesses jurisdiction over the subject matter hereof and over  
12 Respondent.

13 2. The conduct and circumstances described above constitute unprofessional  
14 conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate  
15 records on a patient."), A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might  
16 be harmful or dangerous to the health of the patient or the public."), and A.R.S. § 32-1401  
17 (27)(II) ("[c]onduct that the board determines is gross negligence, repeated negligence or  
18 negligence resulting in harm to or the death of a patient.").

#### 19 ORDER

20 IT IS HEREBY ORDERED THAT:

21 1. Respondent is issued a Decree of Censure.

22 2. Respondent is placed on a practice restriction for **ten years** with the  
23 following terms and conditions:

24 a. Respondent is prohibited from prescribing, administering, or dispensing any  
25 Controlled Substances.

1           b.    Obey All Laws

2           Respondent shall obey all state, federal and local laws, all rules governing the  
3 practice of medicine in Arizona, and remain in full compliance with any court ordered  
4 criminal probation, payments and other orders.

5           c.    Tolling

6           In the event Respondent should leave Arizona to reside or practice outside  
7 the State or for any reason should Respondent stop practicing medicine in Arizona,  
8 Respondent shall notify the Executive Director in writing within ten days of departure and  
9 return or the dates of non-practice within Arizona. Non-practice is defined as any period of  
10 time exceeding thirty days during which Respondent is not engaging in the practice of  
11 medicine. Periods of temporary or permanent residence or practice outside Arizona or of  
12 non-practice within Arizona, will not apply to the reduction of the probationary period.

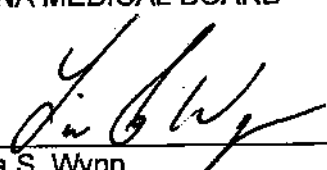
13           3.    This Order is the final disposition of case number MD-09-0279A.

14           DATED AND EFFECTIVE this 5TH day of AUGUST, 2009.



ARIZONA MEDICAL BOARD

By

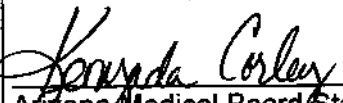
  
Lisa S. Wynn  
Executive Director

21   ORIGINAL of the foregoing filed  
22 this 6th day of August, 2009 with:

23   Arizona Medical Board  
24   9545 E. Doubletree Ranch Road  
25   Scottsdale, AZ 85258

1 EXECUTED COPY of the foregoing mailed  
2 this 6<sup>th</sup> day of August, 2009 to:

3 Martin S. Chattman, M.D.  
4 Address of Record

5   
6 Arizona Medical Board Staff